RESET FORM

14855 Blanco Rd, Suite 400
San Antonio, TX 78216

Wellness Institute of Texas
Live Well. Look Well. Be Well

PHONE 210-802-1133
FAX 210-493-2900

# AESTHETIC MEDICAL HISTORY FORM

Please fill out the form using **Adobe Reader**. Print this form, sign/print blanks that require your signature and printed name.

## PATIENT DEMOGRAPHICS

FIRST NAME _____ MIDDLE _____ LAST NAME _____

DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME NUMBER _____ CELL NUMBER _____ OK to text? Yes No WORK NUMBER _____ EMAIL _____

## EMERGENCY CONTACT

NAME RELATION _____ HOME NUMBER _____ CELL NUMBER _____ WORK NUMBER _____

**OTHER DOCTORS** List other medical providers you are currently seeing

PROVIDER NAME _____ SPECIALTY _____ ADDRESS _____ PHONE NUMBER _____

PROVIDER NAME _____ SPECIALTY _____ ADDRESS _____ PHONE NUMBER _____

## PHARMACY

PHARMACY NAME _____ NUMBER _____

**How did you hear about us? Who referred you to us?** _____

**Which body area(s) or condition would you like treated?** _____

_____

MAR 2018

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**Please answer each of the following questions:**

**1.** Do you have ANY allergies to medications, foods, latex, or other substances?
Please list: _____

**2.** Do you smoke? Yes No Average per day? _____
Do you consume alcohol? Yes No Average per day? _____

| | YES | NO |
|---|---|---|
| **3. Do you have ANY current or chronic medical conditions?** Disclose any history of heat urticaria, diabetes, autoimmune disorder or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness. Please List: _____ | ☐ | ☐ |
| **4. Do you have ANY current or chronic skin conditions?** Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition. Please List: _____ | ☐ | ☐ |
| **5. Are you under doctor's care?** If so, for what? _____ | ☐ | ☐ |
| **6. Do you take ANY medications (prescriptions or non-prescriptions) including vitamins and herbal supplements on a regular basis?** Please List: _____ | ☐ | ☐ |
| **7. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?** Please List: _____ | ☐ | ☐ |
| **8. Are you taking oral steroids (eg. prednisone, dexamethasone)?** | ☐ | ☐ |
| **9. Do you have a pacemaker or external defibrillator?** | ☐ | ☐ |
| **10. Do you have any metal implants under the area being treated?** | ☐ | ☐ |
| **11. Do you have a history of light-induced seizures?** | ☐ | ☐ |
| **12. Do you have a history of Herpes in the area being treated?** | ☐ | ☐ |
| **13. Do you have any open sores or lesions?** | ☐ | ☐ |
| **14. Have you had radiation therapy in the area being treated?** | ☐ | ☐ |
| **15. Do you have a history of keloid scaring or hypertrophic scar formation?** | ☐ | ☐ |
| **16. In the last 6 months, have you used any of the following?** Anticoagulants or blood-thinning medications, photosensitizing medications or anti-inflammatories? List Product, Date Used: _____ | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| **17. In the last 3 months, have you used any of the following products: glycolic acid or other alphahydroxy- or betahydroxyacid products, exfoliating or resurfacing products or treatments?** List Product, Date Used: _____ | ☐ | ☐ |
| **18. Have you had any cosmetic procedures in the past 6 months?** Please Describe: _____ | ☐ | ☐ |
| **19. Have you had any permanent make-up, tattoos, implants, or fillers, including but not limited to collagen, autologous fat, Restylane, etc.?** If yes, please list locations and dates: _____ | ☐ | ☐ |
| **20. In the last month, have you been treated with any Botulinums (eg. Botox or Dysport)?** If yes, please list locations and dates: _____ | ☐ | ☐ |
| **21. Have you taken Accutane (or products containing isotretinoin) or Tretinoin (eg. Retin-A, Renova) in the last 6 months?** | ☐ | ☐ |
| **22. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds/lamps in the last month?** | ☐ | ☐ |
| **- FOR WOMEN ONLY -** | | |
| **23. Are you pregnant or breastfeeding?** | ☐ | ☐ |
| **24. Are your menstrual periods regular?** | ☐ | ☐ |
| **25. Have you been diagnosed with Polycystic Ovarian Disorder?** | ☐ | ☐ |

**Signature:** _____ **Date:** _____

**Reviewed by:** _____ **Date:** _____